

Retro Advisory Committee
Minutes taken April 11, 2006
1:00 p.m. at L&I headquarters in Tumwater

The meeting was called to order at 1:00 p.m. by **Kathy Kimbel**, who was substituting for committee chair Diane Doherty.

Introductions

Committee members present were: Kathy Kimbel (for Diane Doherty), Ann Jarvis, Linda Harvey, James Gurnea, Tammie Hetrick, James Bobst and Debbie Sullivan. Introductions were made around the room beginning with the committee, followed by audience members/attendees.

Approval of Minutes

A motion was made and seconded to **approve** the minutes of the January 10, 2006, meeting as submitted; motion **passed** (was carried).

Improving Occupational Health Practices for Surgical Care

Karen Jost gave a presentation on a pilot project Health Services Analysis is doing to improve access to timely and quality surgical care.

There are some issues with respect to orthopedic and neurosurgical care providers. These are driven primarily by reimbursement levels as well as burden levels and interest in making sure those providers are interested in taking workers' compensation patients, getting them into the office and into surgery in a timely manner.

The purpose is to provide an incentive for quality providers to treat injured workers. The incentive is twofold: to reduce the administrative burden and to provide an increase or new payments for meeting certain occupational health quality indicators. The goal is to provide timeliness of care and to build on the successes from the Centers for Occupational Health and Education (COHE).

This isn't a COHE effort, this is separate. But they have demonstrated success in terms of reducing disability, improving the coordination/communication of care and enabling the attending providers to better understand workers' compensation and the Department as an insurer, and an increase in the likelihood of timely rehabilitation and getting people back to work more rapidly.

There was a literature review that identified 15 potential best practices for surgical care providers relating to workers' compensation. There were 11 doctors that reviewed those quality indicators, and they identified six indicators that they felt were most likely to improve outcomes in workers' compensation.

The first indicator was to complete an activity prescription form (APF) that helps to communicate the information that the Department and the employers feel is the most critical information for the Department to get decisions made in a timely manner. This includes a rehabilitation plan, work status and the estimated return-to-work date, the activity restrictions the worker may have and the follow-up plan.

An attendee asked if once the form is approved and completed, is it going to be on the Claim & Account System.

Ms. Jost answered that at this time it will not be. It is a draft form and it is anticipated that there will be some modifications. Plus with the programming required, the resources are not currently available to put it on-line.

Since it can't be on the Claim & Account Center, the Department is working on programming to specify it as a special document type and are planning to ask the providers to fax it to the Department. When it is received, it will be imaged as a specific document type. Counselors will have access to that system on July 1st; employers already have that access. In addition to that, there will be a note put into the log that says that the activity prescription form was received and it will be routed to the claim manager's imaging mail box.

The second quality indicator the Department is looking at for surgeons is to perform surgery within three weeks of identifying the need for the procedure. The Department has modified this to: perform surgery within three weeks of obtaining authorization for the procedure. The Department typically takes one or two days to authorize the procedure for outpatient surgeries and three or four days for inpatient surgeries. The intent is not to penalize the providers with those additional days in terms of measuring the three-week time frame.

The third indicator the Department is looking at is participation in occupational medicine continuing education.

The fourth indicator is to provide consultation and/or treatment within seven business days of getting the referral. The providers will be reporting to the Department information in regards to if it was rescheduled and why it was rescheduled. This will help the Department understand how the appointments get scheduled and rescheduled.

The fifth indicator is to implement and monitor an intensive rehabilitation plan. This is linked to the activity prescription form because the rehabilitation plan is on that form.

Ms. Jarvis asked if that form will be modified if the worker does not show any kind of improvement. Will there be something that will trigger that the doctor has to now take another look at this because it is not progressing forward?

Ms. Jost answered that if the doctor isn't changing the information on the form, then that would be a trigger to a claim manager. If they see the same rehabilitation plan with the same information or the doctor is indicating "same as previous," that should be a red flag to anybody looking at it.

Ms. Jarvis then asked if there is going to be a time frame put onto that.

Ms. Jost indicated that there is not.

The last indicator, which is really more of an efficiency indicator rather than a quality indicator, the Department expects providers who do enroll in the pilot to endorse the preferred drug list. This means that they can override the preferred drugs on the preferred drug list without any requirements

for authorization. So in order to insure that the Department stays cost effective as a pharmacy purchaser, it is expected that they will maintain a low dispense-as-written rate of less than 10 percent of the prescriptions that they write.

In this pilot project, orthopedic and neurosurgical providers will be identified. They will be state-wide, but it won't be every provider in the state.

The plan is to start July 1, 2006. The location has not been determined. It will be an option for the providers to participate in.

The incentive structure is tiered. The six indicators will be looked at. It is expected that providers will meet the indicator for the threshold for activity prescriptions, which means that for 90 percent of the claims, activity prescriptions will be submitted at appropriate times. For the surgery within three weeks of identifying the need, the expectation is that on 85 percent of the cases where the surgery is performed, it is performed within three weeks of the authorization. For the occupational medicine continuing education, it is expected that some sort of training is received annually. The fourth, providing consultation treatment within seven business days, that is expected to happen 70 percent of the time. On the intensive rehabilitation plan, the expectation is that that plan will be completed every time. And the dispense-as-written is less than 10 percent.

With those six indicators, the expectation is that the activity prescription plan form, the rehabilitation plan and the preferred drug list indicators will all be met.

Saving money, saving time, getting better information are the basics that are expected for them to receive the first level of incentive payment. For the second level, they are expected to meet at least one other indicator of the six. To qualify for the third tier, they would have to meet all six indicators.

The payments will be approximately \$300 more per patient if the provider is in the second level, which is when four of the indicators are met.

The incentive is coming out of the medical aid fund. It is expected that it will reduce delays in care with participating providers and that the activity prescription form will be available.

The pilot will be evaluated. It will start July 1, 2006, and finish June 30, 2008. Then there will be a six-month period where there will be an additional analysis done. Pending that outcome, the program will be expanded statewide, if feasible.

Ms. Hetrick asked if the employer will receive this information at the same time.

Ms. Jost answered that it will be expected that the worker will be instructed to take it to the employer. If it is faxed to the Department, then it will also be available to the employer. The Department does not believe that they can require the doctors to make sure that it is faxed to the employer.

Ms. Hetrick then asked if the doctors are being paid for the training they are receiving from the Department.

Ms. Jost indicated that it is anticipated that the training will need to be done in the doctor's office.

Ms. Hetrick then asked, "Have you done a comparison of these current rates that you plan to increase to current health rates for other insurance companies? Has there been a comparison done to determine where you would be at as far as payments to these physicians for this care?"

Ms. Jost indicated that the Department does not have that data.

Mr. Bobst asked why the APF form is being limited to being completed no more than six times per claimant. They are to be filled out every two weeks for a maximum of six.

Ms. Jost noted that the draft provided for them to review at the meeting was a draft copy of the form for the Centers for Occupational Health and Education's primary care providers. She mistakenly provided the audience with that form instead of the surgical pilot form.

Ms. Jost explained briefly that the two forms are very similar, but the COHE form is geared toward primary care providers instead of surgeons. Currently, the Spokane and Renton COHEs use slightly different forms. They are being consolidated so that they will be using the same form effective July 1. COHE currently has a limit of six forms in twelve weeks.

There isn't a limit on the number of times the form can be filled out by surgeons. There is a limit in the Centers for Occupational Health and Education that the form can be completed every two weeks for a maximum of six visits.

COHE is hoping to start piloting their form July 1st. The expectation is that they will evaluate that in three or four months, and then by the end of the year they will be able to determine if it is effective and be able to roll it out statewide to any provider so that some of the other forms currently used can be discontinued.

An attendee asked if there is going to be a list of the providers participating in the pilot.

Ms. Jost answered that there should be a Web site that will list those providers.

An attendee then asked Ms. Jost to explain the relationship between quality and the use of the PDL.

Ms. Jost explained that it was felt that this was more of an efficiency indicator. The department must be cost-effective in purchasing. Endorsing the preferred drug list reduces burden for providers (not required to get prior authorization for non-preferred drugs). However, it increases potential fiscal liability for the department because providers could always prescribe non-preferred drugs, which are a higher cost. Encouraging providers to minimize dispense as written prescriptions helps to control costs and enables the department to be a cost-effective purchaser of services.

Actuaries Corner

Nichole Runnels presented the actuarial calculation of the January 2006 PAFs for the April enrollments.

A handout was distributed that showed these calculations.

Step 1: The case incurred losses and standard premium for the retro enrollment, and for non-retro employers, were used to calculate the loss ratios, which is the losses divided by the premiums. The percentage difference between the retro and the non-retro loss ratios is the beginning step in the calculation of the targeted refund percentage. The four enrollment quarters looked at for the April 2004 enrollments started with April enrollment experience and included the three prior enrollment quarter experience, the last being the July 2003 enrollment.

Mr. Gurnea asked if the non-retro standard premium is calculated the same way as the retro standard premium.

Ms. Runnels answered that it is the same.

For Step 2, the weighted average of the undeveloped loss ratio differences from Step 1 of the four quarters is taken, and the calculation results in a difference of 19.19 percent. An interest factor of 1.0531 is multiplied by the 19.19 percent resulting in a target refund of 20.20 percent for the April 2004 enrollments.

Step 3: In order to obtain the interest factor used in Step 2, the four quarter moving average of the 10-year T-bond rate is taken and a half percentage point is added. This rate is then accrued for 13.5 months, which is the average amount of time between payment for premiums and collection of refund. This yields 5.31 percent.

Step 4 is to calculate the target refund. The standard premiums are added up and multiplied by the target refund percentage. This yields a target refund amount of \$124,224,000.

In Step 5, current level PAF factors to the other three prior quarterly enrollment periods are calculated and then applied to these prior enrollment developed losses. First, the state fund developed loss ratios to standard premiums are calculated and then the current level factor is obtained by dividing April's loss ratio by each of the other three prior quarterly enrollment loss ratios. These are developed losses before the PAF is applied. Then these factors are multiplied by the developed losses. The current leveling is done so that all four of the quarterly enrollments' refunds will be done using the same rate level adequacy in the next step.

The last step is calculating the PAF which results in the actual refund being closest to the target refund amount. Actual refunds are calculated using different PAFs until we get such a result. The actual refund using a PAF of 1.0228 totals \$124,231,000. The target was \$124,224,000. If a PAF of 1.0229 was used, the actual refund would have been \$124,188,000. If a PAF of 1.0227 was used, the actual refund would have been \$124,242,000. This last step is done for every enrollment.

Going through similar steps, the April 2003 second adjustment results in a targeted refund of 18.44 percent. In going through all the other steps, the resulting PAF is .9221, which gives the total refund for April 2003 of \$90,481,000. For the April 2002 third adjustment, the target refund percentage is 22.14 percent and the resulting PAF is .7155. The total refund for April 2002 is \$87,042,000.

Retro Symposium Update

Diana Finch spoke about the Retro Symposium.

At the last meeting a questionnaire was passed out asking for input about the Retro Symposium that is done every year in conjunction with the Governor's Safety and Health Conference. Responses to this were received. These responses will be used to make decisions about what will happen this year with the Retro Symposium.

The first question gives the count of the feedback that was received on how the retro community would prefer to see the Symposium set up. The choices are to a) continue having it in conjunction with the Governor's Safety and Health Conference; b) keep it in conjunction with the Governor's Safety and Health Conference but move it to the afternoon before; c) start doing them quarterly and not have them in conjunction with the Governor's Safety and Health Conference; d) was other, which was basically just comments.

This decision will need to be made in the next week or two. The Department would like more input.

Ms. Kimbel stated that the Retro Symposium was started at the request of the Retro Advisory Committee members. It was education that was hosted and put on by the Advisory Committee. It was not something that was provided for by the Department. The Department would be happy to provide a resource for whatever topics that were requested, but the invitations, the selected guests would be those that were identified by the Retro Advisory Committee members and separate and apart from the Department. This has changed.

Ms. Finch stated that the goal is to put together a symposium that addresses issues that the retro community wants to hear about. Anyone who attends the Safety and Health Conference is welcome to attend the Symposium. The problem is that the Conference is working with safety issues and the Symposium is done in conflict to that. So anyone who participates in the Conference has to make a choice of going to the Retro Symposium or going to a safety workshop. The goal would be to eliminate that choice.

It was stated from an attendee that initially the Advisory Committee was running the show. There was a lot of interest in it for a while, but the interest has dwindled down.

A question was asked, could part of the challenge right now be that there are a great number of people involved in retro and believe that they have a great deal of information and that they don't need to go to this?

Ms. Finch answered affirmatively. The feedback that was received addressed this. There were two key points that people wanted to hear about, retro 201 and more about claims management.

Mr. Malooly stated that one of the things the Department is looking at is an employer education conference every year or every other year. Other states have done this and they are very well attended. Oregon sponsors an employer education conference that is also well attended.

Ms. Kimbel said that she did go to that and it was very well attended and very informative. It includes law changes, WAC changes that are being made and how it will impact the employer community, any initiatives that are going on in the different departments, claims management and they talked about the preferred worker program.

Mr. Malooly stated that an ambitious legislative initiative is being planned for '07. The Department has talked to business and labor collecting ideas for statutory changes. If that passes, an education conference for next summer would make a lot of sense.

Mr. Gurnea asked if Mr. Malooly would like to address some of the general issues that will be brought up before the legislature.

Ms. Kennedy stated that the Department is just starting to gather issues from both business and labor. This will take place over the next two weeks. On May 30th, the Workers' Compensation Advisory Committee meeting that day is an all-day session, and some of these issues will be discussed. Nothing is finalized at this point.

Mr. Bobst then asked if a report can be given on this at the July meeting.

Mr. Malooly answered affirmatively.

Ms. Kimbel announced that she would make sure this is on the agenda for July.

Committee Vacancies

Ms. Kimbel brought up committee vacancies, noting that some members' terms are up. There was some confusion as to when the terms are up and how the members are selected. Since there wasn't enough information to address this issue, Diane Doherty will get this information out to the Committee members for discussion at the July meeting.

(Recess taken.)

Actuaries Corner (continued)

Bill Vasek gave a presentation on the proposal to update the experience rating plan for 2007.

Mr. Vasek started with an analogy with baseball batting averages to help explain what experience rating is all about. One would give little weight to the experience of baseball players with a few at bats, in comparison with a lot of weight to the experience of players with many at bats when comparing the expected future batting averages.

The baseball analogy was compared to experience rating. How much better than the baseline firm is the given firm expected to be? This is another way to ask what the experience factor is. The steps to calculate this would be 1) weight the past actual loss to the past expected loss based on the firm's credibility to obtain the credible loss; 2) the experience factor is calculated, which is the credible loss divided by the expected loss.

For small employers, very little weight or low credibility is given to past actual losses. When the weighted average is calculated, the credible loss is very close to the expected loss and the experience factor is close to 100 percent.

For large employers, a lot of weight will be given to past actual losses. So the credible loss will be close to the actual loss and the experience factor will be close to the ratio of the actual loss to the expected loss. If the large employer has good experience and the actual loss was much less than expected, they would have a low experience factor. If the actual loss was much higher than the expected, the experience factor will be much greater.

The experience rating calculation is performed by first taking three recent years of experience. When the 2006 experience factor was set, the experience for the three fiscal years 2002, 2003 and 2004 were used. The losses are split up. The first dollars of loss, are called the primary losses and the remainder the excess losses. They are both summed up for the three-year experience period. The primary losses are more predictive of the future experience, thus they carry more weight than the excess losses. The excess losses are less predictive than the primary losses and therefore carry less weight when the weighted average is calculated.

When an experience modification factor is calculated, a weighted average of the actual primary losses with the expected primary losses is taken. Then a weighted average of the actual excess losses with the expected excess losses is taken as well.

There is a portion of loss that is not rated at all. There is a maximum loss amount, and any loss amount that goes above that is eliminated from the calculation.

Both of these credibility weighted primary and excess losses are added together. That numerator is called the "credible loss." This credible loss is divided by the expected losses. This is how the experience modification factor is calculated.

The methodology used today is not perfect. The current formula is difficult to understand and difficult to explain. That is the first problem.

The second problem is a technical problem with the accuracy of experience rating. Experience rating is an estimate as to how well a firm is going to do in the next year. It is actually predicting the future experience of a firm.

A slide was shown depicting the smallest group of firms. These are firms with expected losses totaling \$0 to \$58,000 within the three-year experience period. This showed groups of firms sorted by experience factor using the rating years from 1999 to 2003. Their future loss ratio (normalized

to one) were plotted against their experience factor. After the experience factor is applied, the loss ratio curve should be flat. However the graph showed an upward slope. The debit firms, which are the firms with experience factors greater than 1, have high future loss ratios when they shouldn't. They should have the same future loss ratio as the other firms. The higher loss ratio is the result of not enough credibility being given to their bad experience.

In contrast, the small firms with the lower experience factors, have future loss ratios that are too low. This also indicates that they weren't given enough credibility weight when the calculation was done.

Mr. Gurnea asked if the \$0 to \$58,000 payment of premiums represents most companies in the state.

Mr. Vasek indicated that this size group does represent the most companies.

Ms. Hetrick asked if this is based on dollar amount of premiums or on hours reported to determine the small firm.

Mr. Vasek answered that three years of experience is looked at and an expected loss is calculated. Any firm that had expected losses of less than \$58,000 are included in the small firm group. The firms that are claim free are not included in this group.

Ms. Hetrick then asked if this includes all industries and all risk classes.

Mr. Vasek indicated that it did.

Mr. Vasek then showed a slide which compared the credibility given to small firms in Washington to the amount of credibility that is given to similar firms in both Oregon and California and finally to claim-free firms in Washington.

Ms. Sullivan asked if the new formula, calculating it on the size of the business, does that mean that a business that is large has more credibility than a small business and how would that improve it?

Mr. Vasek indicated that small firms will always have less credibility than large firms and that relationship is not going to change. But the graph shown indicates that small firms are not getting enough credibility. The new calculation should give more credibility to small firms but less than large firms.

A slide was shown depicting the jumbo firms, which are firms with expected losses of more than \$2.2 million during the three-year period for rating years 1999 to 2003. This graph showed a downward slope which indicates that the debit firms have low future loss ratios and they are paying too much in premiums. Too much credibility is given to their experience. The firms that are the credit firms, the good experience, their premiums are too low.

A slide was then shown that compared the credibility given to a large firm in Washington to the amount of credibility that is given to similar firms in both Oregon and California.

In summary, too much credibility is given to large firms; too little credibility is given to small firms. This was also observed by the JLARC auditors in 1999.

The third problem with the system is when a firm is a claim-free firm and they have their first time-loss claim, the experience factor is increased too much.

The Department is proposing to make the experience rating formula more understandable by coming up with tables that are easier to understand. The experience factor will equal credible primary loss plus the credible excess loss divided by the expected loss. The credible primary loss is the weighted average between the actual primary loss and the expected primary loss. The credible excess loss is the weighted average between the actual excess loss and the expected excess loss. This is the same calculation that is currently being used, but it is easier to understand. The tables of the primary and excess credibilities will be given in rule.

The second change that will be implemented is to help increase the accuracy of experience rating by increasing credibilities for small firms and decreasing credibilities for medium to large firms.

The third change that will be implemented is a deduction will be taken on the non-disability claim charges which will reduce the impact of the first disability claim. These claims will be reduced by the lesser of twice the average non-disability claims (about \$1,390) or the original total cost of the claim.

Ms. Jarvis asked if this was scheduled to be implemented on January 1, 2007.

Mr. Vasek answered that it was.

Next Meeting

Ms. Kimbel then stated that the next meeting is scheduled for July 11th. Agenda items include 2007 legislative proposals and committee membership.

Adjournment

There being nothing else to come before the group, the meeting was adjourned at 2:45 p.m.